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SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF POPULATION, FAMILY & REPRODUCTIVE HEALTH

KNUST

DETERMINANTS OF POSTPARTUM FAMILY PLANNING UPTAKE AMONG  
WOMEN IN THE KUMASI METROPOLIS, GHANA

BY

**DR. NATASHA ASAMOAH (MB. Ch. B)**


NOVEMBER 2015

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NOVEMBER 2015

## DECLARATION

I declare hereby that with the exception of references to other people's work that has been duly noted, this work is the result of original research conducted by me under supervision. It contains no materials previously published by another person, which has been accepted for the award of any degree in this university or elsewhere.

SIGNATURE..... DATE.....

NATASHA ASAMOAH (DR.)

(CANDIDATE)

SIGNATURE..... DATE.....

DR. EASMON OTUPIRI

(ACADEMIC SUPERVISOR)

SIGNATURE..... DATE.....

MR. EMMANUEL NAKUAH

(HEAD OF DEPARTMENT)

## ABSTRACT

A high fertility rate leads to rapid population growth and hinders development. Over the past few decades, countries the world over have put in place policies to improve the

health and well-being of their people by encouraging family planning uptake, especially in postpartum women. This is because though there has been an overall increase in family planning in developing countries, many women end up with unintended pregnancies before resumption of their first menses. In Sub-Saharan Africa, almost one-third of postpartum women are at risk of getting pregnant within 2 years of delivery as they are having sex without any form of contraception. Several factors have been proposed as being the reasons for the low uptake of family planning among women in the postpartum period.

This cross-sectional study sought to determine the demographic, social and provider-related factors associated with postpartum family planning uptake among women within the Kumasi metropolis. A total of 550 women, in the reproductive age (up to 1 year postpartum) were selected via multi-stage sampling, to participate in the study in five (5) private health facilities.

Analysis of data obtained from 223 users and 327 non-users of postpartum family planning revealed an average postpartum family planning prevalence rate of 40.5%.

Of the socio-demographic variables analyzed, age of women significantly influenced uptake at both the bi-variate and multivariate levels. Though there was a general awareness of family planning, women had inadequate information about return to fertility after delivery and the methods that could be adopted for postpartum use.

In terms of service accessibility, variables such as location of family planning services (in relation to health facilities), means of transport to services, distance to services from place of residence, payment for the use of family planning services and the availability of contraceptive methods of a client's choice were shown to have some relationship with postpartum family planning uptake.

The quality of family planning services had some relationship with postpartum uptake. Service delivery was generally good however, a third of users were uninformed about side-effects and a third were unwilling to return to service providers, Communicating with one's partner about family planning and receiving financial assistance from one's partner significantly influenced postpartum family planning uptake.

Interventions should be directed at utilizing all missed opportunities to properly educate women about postpartum contraception and its benefits. Providers should be regularly updated on their level of information and motivated to give off their best in the provision of service. Policies should be formulated to increase male-involvement, as this will go a long way to improve patronage of family planning in women as soon as they deliver.

### **DEDICATION**

This thesis is dedicated to the Almighty God Jehovah who has been my source of strength, wisdom and perseverance. It is also dedicated to my wonderful family, immediate and extended who have helped me to stay focused even in the toughest of times.

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## **ACRONYMS/ ABBREVIATIONS**

AIDS - Acquired Immune Deficiency Syndrome

CHAG - Christian Health Association of Ghana

FP - Family Planning

GDHS - Ghana Demographic and Health Survey

GHS - Ghana Health Service

HIV - Human Immunodeficiency Virus

IUCD - Intrauterine Contraceptive Device

KMA - Kumasi Metropolitan Area

KMHD - Kumasi Metropolitan Health Directorate

LAM - Lactation Amenorrhoea Method

MCH - Maternal and Child Health

STI - Sexually Transmitted Infection

USAID - United States Agency for International Development

WHO - World Health Organization

WIRA - Women in the Reproductive Age group



## **CHAPTER ONE 1.0 INTRODUCTION**

### **1.1 Background of Study**

Following the Fourth Beijing conference on Women and Development in 1995, women have become more determined to have a better quality of life. This improvement in quality of life includes having the number of children that they want, when they so desire without having to abandon the pursuit of their goals and aspirations. In 1970, the Ghana National Family Planning Programme was established under the then Ministry of Finance and Economic Planning with the belief that it is a fundamental human right that couples should have the opportunity to decide freely the number and spacing of their children (Odoi- Agyarko, 2003). Studies have shown that there are several benefits to utilizing family planning. These include improvement in the status of women, female empowerment, reduction in pregnancy-related complications that culminate in the prevention of loss of human resources and revenue to the state. The World Health Organization Technical Consultation on Birth Spacing (2005) reported that for the healthiest outcome for mother and baby, couples should wait at least two years after the birth of their last infant before they try to conceive again to reduce risks of adverse maternal, peri-natal and infant outcomes (WHO, 2005).

Family planning allows individuals and couples to anticipate and attain their desired number of children by the spacing and timing of their births. This is achieved through the use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (WHO, 2012). Postpartum

programs have been an integral part of family planning since its inception. The first organized postpartum program in family planning literature was in 1930 at the Johns Hopkins Hospital (Zatuchni, 1970). Over the next three decades, however, neither international nor domestic family planning efforts were directed at women who were recently pregnant. Then in 1966, the Population Council began a demonstration project to provide family planning services to women after they gave birth or had abortions, focusing primarily on developing countries; this also included women of low socio-economic status in the United States (Zatuchni, 1970). This project known as the "International Postpartum Program," was recognized as being universally successful. Maternity-based and hospital-centred family planning was eventually extended to include 138 hospitals in urban areas of 21 countries, serving over 1.1 million women (Castadot et al., 1975; Taylor & Berelson, 1970). The International Postpartum Program was so designated because family planning services were located in institutions where antenatal services, abortion, labour and delivery, as well as postpartum care took place, and not because contraception was necessarily initiated at a specific time after childbirth or termination of pregnancy.

During the postpartum period, there is a great need for information dissemination and service provision to sustain the health of both the mother and newborn baby, yet few organizations have made it a priority to address women's reproductive health and fertility needs, especially during the year following delivery. The situation has been compounded by the scarcity of postpartum care in many countries, creating a major public health concern (Fort, Kothari & Abderrahim 2006). Quality family planning services increase knowledge about contraception and acceptance of effective methods, as well as influencing method choice (RamaRao & Mohanam, 2003). Women sometimes think they will not get pregnant so soon after childbirth, and so do not practise any form of contraception. It is however those who are exclusively



breastfeeding, who have not menstruated since their most recent birth and whose children are less than 6 months old who are about 98% protected against the risk of pregnancy because they are essentially practising Lactational Amenorrhoea method-LAM (WHO, 2007). A study carried out in Peru and Indonesia to assess the dynamics of contraceptive use and breastfeeding during the postpartum period revealed that although the likelihood of contraceptive adoption was highest in the month women resumed menstruation in both countries, about 10% of subsequent pregnancies occurred to women before they resumed menses (Becker & Ahmed, 2001). These results emphasize the importance of integrating breastfeeding counselling and family planning services in programmes serving post-partum women, as a means of enabling those who wish to space their next birth to avoid exposure to the risk of a pregnancy that may precede the return of menses (Becker & Ahmed, 2001).

There seems to be some ambiguity as to what the postpartum period is and though it generally refers to the first six (6) weeks following the birthing process, it has now been extended to span the first year after delivery. It is categorized as either immediate postpartum (up to 6 weeks post-delivery) or extended postpartum (7 weeks up to 1 year).

## **1.2 Problem Statement**

Family planning enhances efforts to improve family health. However, traditional beliefs, religious barriers, misconceptions and the lack of male involvement have weakened family planning interventions. Research has confirmed a high "unmet need" for family planning in sub-Saharan Africa (WHO, 2009-2012) while the 2008 Ghana Demographic and Health Survey reports that about 35% of married women have an



unmet need for family planning; 22% for spacing and 13% for limiting. The root causes of this unmet need are largely unknown though there is great social and demographic significance (GSS/GHS/ICF Macro, 2009). Bongaarts and Bruce in 1995, showed that lack of knowledge, fear of side-effects and disapproval by husbands were the main reasons why women who were initially motivated refused to use contraceptives. In many countries, women who are pregnant or have recently given birth are not informed about family planning or offered a contraceptive method to prevent another pregnancy as part of their Maternal and Child Health (MCH) services, even though the majority of them do not want another birth within two years (Foreman, 2011). Some women have raised concerns about the attitude of service providers when they visit family planning centres. It is said that some are unfriendly and not particularly patient or well informed to allow clients clarify any doubts they may have about the contraceptive methods. In other instances, there have been complaints of facilities being sited at far off locations. Postpartum women are limited in their mobility as they are still recovering from the birthing process. They get discouraged by the long distances they will have to travel and will therefore not access the services. For other women the issue is preference for particular contraceptive methods. Thus when they come to the family planning centres and these methods are not available, they may decide not to patronize the services. Lack of support from spouses has been identified as a major cause of low uptake. Ezeh in 1993 revealed in his work that many women who wanted to avoid pregnancy, using contraceptives, were unable to do so because their husbands objected. These are a few of many factors that may separately or collectively work to prevent women who have recently delivered from recovering fully and enjoying life with the newborn baby.

### **1.3 Justification/ Rationale**

In many developing countries, death and poor health among women and newborns have remained too high for too long, in spite of decades of international declarations for urgent action to be taken to improve wellbeing among these groups. Ghana is currently striving to become one of the fastest growing economies in Africa. This trend will however not continue if measures are not put in place to control the fertility rate and reduce other health indicators such as infant and maternal mortality rates which currently stand at 50 per 1,000 live births and 451/100,000 live births respectively (GSS/GHS/ICF Macro, 2009). Postpartum family planning is an effective way of dealing with this situation as it offers women in the reproductive age group (15- 49 years) a means of effectively spacing or limiting their births and consequently avoiding complications of unwanted pregnancies. This will lead to an improvement in the health of women and their children, families will be more productive, save more and have better prospects for their children. The economy will grow and the pressure on natural resources and infrastructure will reduce. In effect we will be closer to achieving the targets of the fourth and fifth Millennium Development Goals.

This study seeks to determine factors that may influence the decision of women in the postpartum period towards contraception and help to make recommendations towards improving its use.

#### **1.4 Conceptual Framework/ Hypotheses**

**Figure 1.1 Conceptual framework**

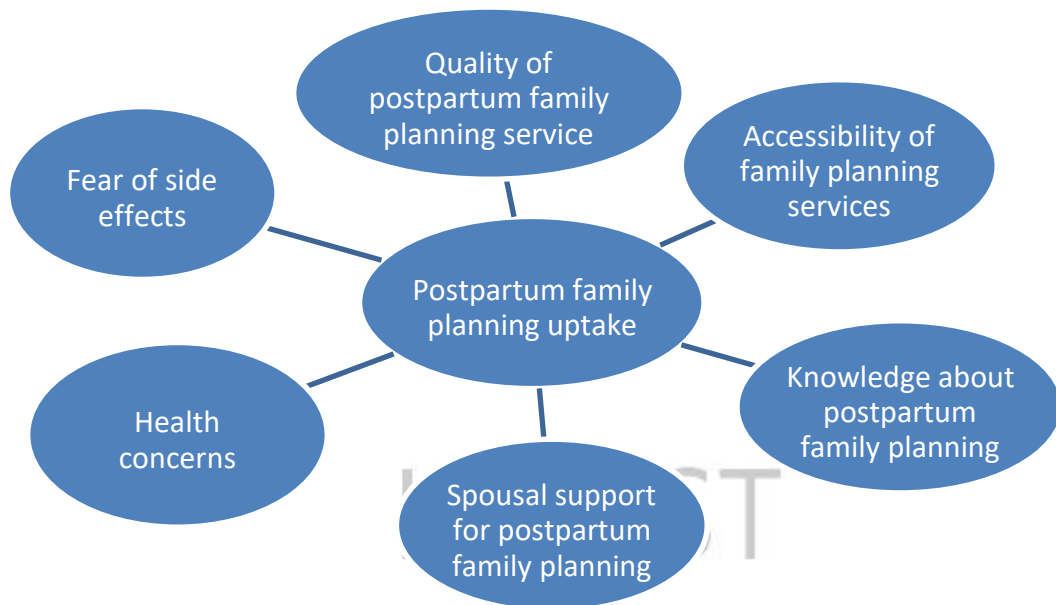


Figure 1.1: Conceptual framework showing factors influencing postpartum family planning uptake

(Source: Author's construct, 2013)

**Null Hypothesis (H<sub>0</sub>):** (i) Being informed about family planning has no influence on postpartum uptake

(ii) Accessibility of service does not influence Postpartum Family planning uptake.

(iii) Quality of family planning service does not influence postpartum uptake

(iv) Spousal support does not influence postpartum family planning uptake.

### **1.5 Research Question:**

Which factors influence postpartum family planning uptake among women in Kumasi?

### **1.6 Objectives**

#### ***1.6.1 Main Objective:***

To determine the factors that predict uptake of family planning among postpartum women in the Kumasi metropolis.

#### ***1.6.2 Specific Objectives:***

- To determine the postpartum contraceptive prevalence rate in the Kumasi metropolis
- To determine whether postpartum women are informed about family planning.
- To determine the accessibility of family planning services to postpartum women. - To ascertain the influence of quality of care on the uptake of family planning among postpartum women.
- To assess the influence of partner support on postpartum family planning uptake

#### **1.7 Profile of Study Area**

The Ashanti Region is the second most urbanized region after Greater Accra. As the third largest region it occupies 24,389 square kilometres of Ghana's land surface. According to the 2010 census it is the most populous region with a population of 4,780,380 (Ghana Statistical Services, 2011).

The Kumasi Metropolitan Assembly (KMA), the most populated of the 27 districts in the Ashanti region will be the site of the study. With an estimated 2012 population of 2,146,441 and an annual growth rate of 2.7%, it forms 42.6% of the region's population. Politically, there are 10 sub- metropolitan areas in the KMA. These are; Manhyia, Tafo, Suame, Asokwa, Oforikrom, Asawase, Bantama, Kwadaso, Nhyiaeso and Subin. The proportions of the population in the metropolis in terms of religion are; Christianity- 78.8%, Islam- 16.0%, Traditional- 0.3% and Others- 0.7%. Apart from these four groupings, there is another group termed “No Religion” which constitutes about 4.2% but this could vary (Ghana statistical Services, 2011 and KMA, 2006). Although the

Kumasi Metropolis is dominated by people of Asante ethnicity, almost all the other ethnic groups in Ghana are represented. This makes it an ideal area for the purposes of this research.

There are 209 communities in Kumasi. The health needs of these communities are catered to by five (5) sub- metropolitan health areas which are: Asokwa, Bantama, Manhyia-South, Manhyia-North and Subin.

Table 1.1: Population Distribution per Sub-Metropolitan Health Area

<b>Sub-Metropolitan Area</b>	<b>% of the Total Estimated Population</b>	<b>No. of Communities</b>
Asokwa	30.3	50
Bantama	24.2	50
Manhyia South	18.6	61
Manhyia North	16.0	25
Subin	10.9	23
<b>Metropolis</b>	<b>100</b>	<b>209</b>

Source: (KMHD, 2008)

The 2012 population profile gives the percentage of women in the reproductive age group (WIRA) as 23.3% (497,974). Health services in the Metropolis are organized around many hospitals, clinics and maternity homes. There is 1 Teaching Hospital, 5 District Hospitals (with one designated as the Regional Hospital), 4 QuasiGovernment, 7 Health centres, 3 CHAG institutions, 13 industrial clinics, 113 private hospitals/clinics, 55 maternity homes, 15 private laboratories, 672 pharmacies and 510 chemical shops. Majority of the health institutions in the metropolis are privately owned with 13 of the private health institutions being industrial clinics. Some of the sub-metro government hospitals serve as regional sites for different medical services, such as ear, nose and throat (ENT) surgery or sexually transmitted infections (STI) care. The



Kumasi Metropolitan Health Directorate oversees all sub-metropolitan district hospitals. Private facilities are under the jurisdiction of the Regional Health Directorate. There are also 122 outreach stations in Kumasi, located throughout the five sub-metropolitan areas (KMHD, 2008).

According to the 2012 report on reproductive health, 48,254 women were registered for antenatal care services within the Kumasi metropolis. A total of 41,334 deliveries were recorded with 38,507 returning for postnatal care during the same period. Family planning uptake, comprising new and continuing users, was 43,385.

**Table 1.2: Reproductive health indicators for KMA, 2012**

	ANTE-NATAL CARE REGISTRANTS	DELIVERIES	POST NATAL	FAMILY PLANNING ACCEPTORS
METRO TOTAL	48254	41334	38507	43385
%	56.2	48.1	44.5	8.8

Source: Kumasi metropolitan health directorate annual report, 2012

## **CHAPTER TWO 2.0 LITERATURE REVIEW**

### **2.1 Introduction**

During the postpartum period, the new mother goes through several changes that may be physical, psychological or physiological in nature. Physically there is a reduction in weight as a result of the body getting rid of the excess fat and water that are accumulated during pregnancy. The abdomen begins to decrease in size as the uterus undergoes involution. This is associated with cramping and bleeding per-vagina but this reduces and ceases altogether within six weeks. Between 25% - 85% of women experience a few days of moodiness, discouragement and depression and this is referred to as the "baby blues." For a few women, this may get worse and when it does not improve, it is then said to be a case of Postpartum Depression. Physiologically, there is a gradual decline

in the levels of pregnancy hormones with a simultaneous increase in the hormones that support lactation because the newborn begins to breastfeed.

Each year, a third of the hundreds of pregnancies that occur are unintended, and majority of these occur in developing countries (Guttmacher Institute, 2009). The reason for this occurrence is the fact that postpartum women are usually vulnerable to pregnancy before they even realise it, however most of them may not be using any form of family planning. The return to ovulation may occur prior to the return of the menses though the woman may have no experience of the return to fertility. Thus a postpartum woman who is sexually active but is not using an effective method of family planning can get pregnant in the months preceding the return of her menstruation. A study of postpartum ovulation and menstruation showed that in 20% of women who did bottle-feeding and 45% of those who breastfed, ovulation occurred before onset of menstruation (Howie et al., 1982).

## **2.2 Importance of Postpartum Family Planning**

Data obtained from several studies have led many to conclude that it is better to initiate contraception immediately after delivery in order to avoid the potential consequences (Ross et al., 1989). Several benefits have been attributed to the early initiation of family planning in the postpartum period. First of all, it is an effective means of preventing unintended pregnancies. It is estimated that unintended pregnancies will drop by greater than two-thirds, from 75 million in 2008 to 22 million per year if the need for both family planning and maternal and newborn services are met (Singh et al., 2009). Women will therefore not have to worry about getting pregnant when they are not ready to do so. Unsafe abortions will also decline as women will not get desperate and resort to all sorts of unsafe means to terminate unwanted pregnancies (Singh et al., 2009).



Maternal deaths are expected to reduce drastically with a concomitant decline in the number of stillbirths, neonatal and infant mortalities (Singh et al., 2009). Overall, public sector spending will reduce and the productive life years lost as a result of death and disability will be greatly minimized.

### **2.3 Family Planning Methods for Postpartum Women**

There are several family planning methods that can be used by postpartum women and initiation can even be immediately after delivery. Some methods are recommended for all women while others depend on the feeding option chosen for the newborn. For all women, barrier methods such as condoms, diaphragms and cervical caps can be used immediately after delivery. Intrauterine devices and female sterilization can be initiated from the immediate post-delivery period up to about 48 hours if not, then will have to be delayed till 4 and 6 weeks later respectively. Male sterilization/vasectomy which can be done immediately post- delivery, is an ideal method. This is because the 12-week period that it takes before the male is infertile coincides with the normal practice of postpartum abstinence for most couples. For breastfeeding women, the Lactational Amenorrhoea Method (LAM) is started immediately after delivery up to six months; progestagens can be started 6 weeks post- delivery while combined progesterone-oestrogen contraceptives are started after 6 months. In the case of women who are not breastfeeding, other recommended methods are progestagens right after delivery and the combined method 3 weeks after delivery (USAID, 2008).

### **2.4 Prevalence of postpartum family planning**

Adoption of postpartum contraception enables women to have a more fulfilled life even as they have the opportunity to pursue goals that they might otherwise have been unable

to pursue. The prevalence of postpartum family planning varies from country to country with high rates being recorded in developed countries and low rates in developing countries. In Indonesia for instance, postpartum contraceptive rates are as high as 75% (Gebreselassie, Rutstein and Mishra, 2008) compared to Zambia which has a prevalence rate of only 33% (Ross and Winfrey, 2001). The postpartum contraceptive prevalence rate for Ghana in 2012 was approximately 36% with the Kumasi Metropolitan Area recording a rate of 15.5% for the same period (KMHD Annual report, 2012).

## **2.5 Factors Influencing Postpartum Uptake of Family Planning**

In the past few decades, fertility rates as well as maternal and infant mortality rates have declined in many developing countries. This is largely due to an increase in the use of modern family planning and improvement in infant and maternal care. In spite of this progress, infant and maternal deaths remain extremely high. In 2003, an estimated 200 million women in developing countries had an unmet need for modern contraceptives. Seventy-five (75) million had unintended pregnancies (Singh et al., 2009) and 20 million of these women had unsafe abortions (WHO, 2007). Every year, more than a half million women die from pregnancy-related causes (WHO, 2007), and nearly four million newborns die from mostly preventable conditions.

Women have given numerous and complex reasons for not using modern contraceptives though they would rather not get pregnant; some of these reasons have been expanded on as follows.

### ***2.5.1 Information on Postpartum Family Planning***

The first reason given by women is the lack of information on postpartum family planning and its benefits during the ante-natal and early post- delivery period. Many

women report that they receive no advice concerning the need for family planning when they deliver; as a result, they go home thinking they are not at risk of getting pregnant only to realise otherwise. In Mexico where family planning advice has been incorporated into the prenatal care guidelines, evaluation of the effect of this counselling showed that 47% of women used a modern contraception method. Those who received family planning advice during prenatal care were more likely to use a contraceptive than were those who did not receive such advice (OR= 2.2) (Barber, 2007). In Ethiopia, 17% of women had no knowledge of a source for a method while 13% of women did not know of a method (Korra, 2002). Also rural uneducated women who had never discussed family planning either at home or at a health facility, with a health worker had a significantly higher unmet need. Naayu et al, (2013) revealed that there are many missed opportunities for family planning counselling in Kenya, and service users in focus group discussions confirmed this view. One woman reported that she had attended the requisite 4 ANC visits but had not been told anything; whatever information she received was through friends.

#### ***2.5.2 Accessibility to postpartum family planning services***

Following the birthing process, the new mother is limited in her mobility as her body is recovering from the stress of pregnancy and delivery. The situation is aggravated in the event that she had to undergo Caesarean section or had an episiotomy or tears. Proximity of a health facility to such a woman will therefore be an important determinant of whether she will access the family planning services or not. In Kenya's slums, the proximity to family planning service providers produced results that were interpreted as, the farther away the client was from the service provider, the less likely she was to seek the services. This negative impact was attributed to the fact that the

farther away the client was from the provider, the higher the cost for transportation and transaction as well as waiting and travelling time (Okech, Wawire & Mburu, 2011). In rural Burkina Faso, living 10-15km away can be a barrier to attending antenatal, let alone postnatal clinic. Women in the rural communities are in charge of the household and farm, and therefore are reluctant to lose a day's work to visit the service delivery point. Most family planning services are not free and require the client to pay some money in order to utilize them. Women who therefore have no gainful employment may find it difficult to do so. Additionally, some women are unable to get a method of family planning because they are unable to find money to pay for it because their partners perceive it as not being urgent (Daniele, 2014). Often this means the women will have to forgo their first choice of contraception as they find it difficult getting the money for the contraception and transportation from their partners. For these women, if a method is unavailable and they are asked to return later with the correct amount in order to receive the desired method, it will be problematic as they cannot afford the cost of a second trip.

### ***2.5.3 Quality of family planning services***

Pregnant and postpartum women are in a delicate state and are greatly affected by what is communicated to them and the manner in which it is communicated. It is vital that service providers create a warm, receptive environment for counseling and give the women the opportunity to ask questions to enable them make informed choices. Though services may be technically available, women and girls do not feel they can use them because of negative attitudes of health workers that push them away (Averill, 2012). Recent analysis of Demographic and Health Survey data from 15 countries showed that 7-27% of women discontinued use of contraceptives during the first year for broadly

classified quality-related reasons (RamaRao et al., 2003). A study in Sierra Leone following the conflict revealed that the quality of care was hampered by a lack of counseling skills in reproductive health staff, resulting in clients not receiving accurate information on family planning methods or referrals not being made for different methods when women experience side effects (USAID, 2008). In Burkina Faso, once a method is chosen, the woman is usually told about potential side effects such as spotting or amenorrhea, although some disadvantages are never discussed (eg. lack of protection against STIs/HIV for hormonal contraception). In other instances, the information given is partial because it is influenced by the provider's own opinions, personal experience or religious opposition to particular methods. Some methods are not promoted because of an apparent lack of demand. The female condom, for instance it was said to, have too many protocols, be too big and unpopular with the girls. The response of one rural health centre was to stop ordering them (Daniele, 2014).

For many women availability of a particular family planning method influences whether they will come to the family planning clinic after delivery. In rural Malawi, it was shown that for women who used modern contraceptives, the commonly used method was Depo-Provera injectable. The reason given was that it was easy to hide its use from their husbands (Chipeta, Chimwaza & Kalilani-Phiri, 2010). In the slums of Kenya it was revealed, by the women who were interviewed, that services were rated as being of high quality and likely to be patronised when a preferred method of contraception was available (Okech, Wawire & Mburu, 2011).

#### ***2.5.4 Partner Support in Postpartum Family Planning***

Due to the psychological changes a woman undergoes in the period after delivery, it is crucial that she receives all the support she needs to ensure speedy recovery and enable



her take good care of her newborn. Family support plays a vital role at this stage and in most African settings, the new mother usually will go and stay with her mother or a close female relative who will assist her in caring for the baby and allow the mother to have periods of rest. The desire to use contraception as a means of preventing unwanted pregnancy is usually high in most African women, however the attitude or response of the partner, in most cases will determine whether she will go through with it or not. Toure (1996) indicated in his paper that men often have positive attitudes towards family planning but their wives tend to believe that they are opposed to the idea. His report also stated that there was a positive association between spousal communication and the use of family planning. However one- tenth of married women have reported that the main reason behind non- use of contraceptives is because their husbands disapprove (Drennan, 1998). This is consistent with studies in Ghana (Ezeh, 1993) which reveal that spousal influence tends to be an exclusive right of the husband rather than a mutual decision. In Kenya, partner approval was the most important determinant in respondents using family planning services. Hence, the probability of respondents using family planning services was as high as 83% when consent from partners was given, compared to when none was given (Okech, Wawire & Mburu, 2011). These reports however contradict findings from the 2008 Ghana Demographic and Health Survey which revealed that in only 3% of non-users was the disapproval of a husband or partner cited as the reason (GSS/GHS/ICF Macro, 2009). Daniele (2014) also reinforced the former view with her findings which concluded that, women who are convinced of their desire to use contraception are sometimes unable to persuade their partners to agree thereby having to sometimes conceal the use of contraceptives by visiting the clinic at night and leaving their cards at the clinic. Sometimes however, threats of a partner taking on another wife may be enough to dissuade or stop a woman from using contraception.

## **CHAPTER THREE**

### **3.0 METHODOLOGY**

#### **3.1 Study Methods and Design**

A cross-sectional study was conducted which led to the generation of both descriptive and analytic data. The social and demographic variables of the respondents were clearly defined and this was followed by an analysis of the relationship between the socio-economic and provider-related variables and the postpartum uptake of family planning to determine whether there was statistical significance.

A quantitative approach was employed to determine the relationship between factors, and provide an in-depth understanding of the established relationships.

#### **3.2 Study Population**

Women of reproductive age (15- 49 yrs) who were in the postpartum period were eligible for inclusion in the study. This consisted of women in both the immediate postpartum period (up to six weeks) and the extended postpartum period (from six weeks up to one year). Respondents were chosen from private health facilities in the Kumasi metropolis where both delivery and family planning services are provided. Women who participated in the study did so of their own volition after they had been counseled on the rationale and objectives of the study. They were also assured that there was minimal to negligible risk associated with partaking in the study.



### 3.3 Sampling Techniques and Sample Size

A multi-stage sampling method was employed for the study. All the five (5) health sub-metropolitan areas were included in the study.

A sampling frame, which consisted of a list of all the private health facilities within the metropolis, was obtained from the Metropolitan Health Directorate. This list was then shortlisted to include only those that offered both delivery and family planning services. Using simple random sampling method, five (5) private health facilities were selected for the study. This was done by writing the names of the private clinics on pieces of paper and selecting one health facility within each sub-metropolis. At the health facilities, simple random sampling method was used to select the clients who were interviewed. Here, clients who fell within the postpartum period were randomly chosen to participate; this was done so that adequate number of respondents would be obtained, as per the quotas allocated to each facility.

The attendance records of the facilities for the six (6) months preceding the survey were used to estimate the average number of women who delivered at each health facility and returned for postpartum care. This was then used to determine the number of women who were interviewed. Within the Bantama sub-metropolis for instance, the numbers of deliveries for the six (6) most recent months was; 55,48,44,62,58 and 51 respectively, giving an average delivery rate of 53. This was repeated for all the facilities with the averages being added up to obtain a total number from which the proportion of respondents to be interviewed at each facility was deduced. The sample size for the study was calculated based on the assumption that 50% of the women who delivered in the metropolis used contraception and 50% of them did not.

The formula was given as:

$$n = \frac{Z^2 pq}{d^2} \quad (\text{Kirkwood and Sterne, 2003})$$

Where, n is the desired sample size,

- z is the standard normal deviation 1.96

- p is the proportion of women in the postpartum period assumed to be using contraceptives; assumed to be 50%; q is 100% - p; d is the degree of accuracy desired at 0.06

- n was therefore calculated as:  $(1.96)^2 (0.50) (0.50) / (0.06)^2 = 266.77$  which is approximately 270

To cater for non- respondents and incomplete questionnaires, 10% of the sample size was added  $(10/100 \times 270 = 27)$

- n was obtained as:  $270 + 27 = 297$ .

Using the default design effect (deff) of 2.0, to achieve the same reliability that a simple random sample (SRS) would produce, the sample size (n) was multiplied by 2;

$$297 \times 2 = 594 \text{ (approximately 550)}$$

A final sample size (n) of 550 postpartum women were surveyed. Based on the average delivery rate obtained for each of the five (5) health facilities simple proportion was used to determine the number of respondents that were interviewed at each of the facilities.

### 3.4 Data Collection Techniques and Tools

Prior to commencement of the study, permission was sought from heads of the health facilities for the study to be conducted in their facilities. Service providers at the family planning units of the facilities chosen to partake in the study, were consulted and after thorough explanation of the study to them, they were requested to provide all the needed assistance.

Questionnaires to be used for the research were developed using the 2008 Ghana Demographic and Health Survey and PMA2020 female respondent questionnaires as templates. Before administering the questionnaires, the purpose of the study was explicitly explained to all respondents to ensure full comprehension and eliminate any ambiguity. Literate respondents were allowed to fill questionnaires themselves while non-literate respondents were aided to complete them. The local language was used in the administration of questionnaires to respondents.

Open-ended and closed questions were posed to respondents for data collection via the questionnaires. Information on demographic and socio-economic status of the women was collected in addition to that which pertained to the specific objectives.

### **3.5 Study Variables**

Socio-economic and demographic data: age of respondents, ethnic group, religion, parity, level of education and their occupation.

**Information on postpartum family planning:** Questions were asked to determine how well informed respondents were about postpartum family planning, where they obtained this information and their awareness of the various methods of contraception that could be used in the postpartum period. Further enquiries were made to ascertain their knowledge on how long after delivery a woman was most likely to get pregnant and the factors that influenced this return to fertility after childbirth.

**Accessibility to family planning services:** Information was sought on the proximity of family planning centres to respondents, how they got to the centres from their homes and whether it was financially conducive. They were asked about

contraceptive preference, the availability of these methods at facilities and whether this played a role in utilization of contraception.

**Quality of postpartum family planning service:** Women were asked about the quality of care provided at family planning centres, whether they were satisfied with the attitude of service providers, the environment in which they were attended to and the timeliness of services.

**Partner support for postpartum family planning:** The influence of partners in contraceptive use by postpartum women, was assessed by asking about partners' views on postpartum contraception and the provision of emotional and financial support where necessary.

### **3.6 Pre-Testing**

Questionnaires were pre-tested at one of the private health facilities in the metropolis that was excluded from the study. This was to help determine whether questions were clear and concise and free of any form of ambiguity. It also used for the estimation of the duration of the study. Corrections and revisions were made to the questionnaires with some open questions being changed to close-ended and others requiring specific answers instead of ranges being used. Final approval was then obtained before commencement of the study.

### **3.7 Data Handling and Storage**

After data had been collected, all incomplete questionnaires were discarded. Completed questionnaires were arranged in an orderly and chronological manner to make data handling easier. Data were stored in a secure file with a password.

### 3.8 Data Analysis

The data collected were cleaned of all uncompleted questionnaires and the results entered into a Microsoft Excel (version 2010) spreadsheet. Analysis was then done using STATA version 11.3. Prior to the onset of analysis, questionnaires were coded. Uni-variate analysis was conducted to describe the exposure and outcome variables independently. Bi-variate analysis was then done to determine if there existed any association between the exposure and outcome variables. Pearson's Chi-square test ( $\chi^2$ ) was employed to assess the effects of the covariates on the users and non-users of family planning.

Multivariate analysis was then conducted to further analyze variables that were found to be significant at the bi-variate level. This was done using binary logistic regression which reported the odds ratios and determined the association between the dependent and independent variables. Crude odds ratios (OR) were calculated to determine the presence of significant associations between the independent variables and the dependent variable. Adjusted odds ratios (AOR) were then computed to control for confounders that may be the potential causes of the associations.

A  $p$ -value of less than 0.05 was used as the cut-off for statistical significance. A low  $p$ -value indicates that the predicted probability deviates from the observed probabilities in a way that the binary distribution does not predict. The HosmerLemeshaw (H-L) test was used to assess the fit of the model by comparing the observed and the expected frequencies. When the H-L test is significant it means that the observed counts and those predicted by the model are not close, and the model does not describe the data well. When the H-L test is not significant it means that the observed and the predicted counts are close and the model describes the data well.



### **3.9 Ethical Consideration**

The Kwame Nkrumah University of Science and Technology/Komfo Anokye Teaching Hospital Committee on Human Research, Publications and Ethics approved the study. The Metropolitan Health Management Team provided administrative clearance. Written consent was sought from respondents with the assurance of confidentiality given for all information that was obtained in the study.

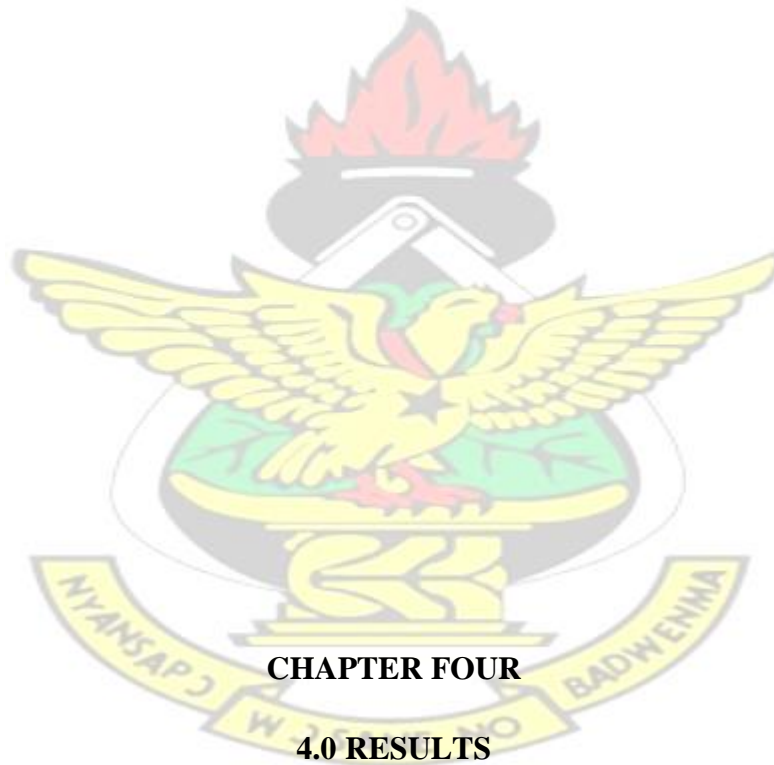
### **3.10 Limitations of the study**

1. Study conducted at private health facilities may not be reflective of public health facilities.
2. There was the probability of incorrect information being provided to the researcher by those who filled the questionnaire themselves.
3. Information transcribed by research assistants for non-literate respondents could have been done wrongly.
4. A limited number of private facilities had both delivery and family planning services.
5. Inadequate numbers of women using family planning in the immediate postpartum period made it impossible to compare the two postpartum periods.

### **3.11 Assumptions**

1. It was assumed that those who participated in the study gave correct responses.
2. It was also assumed that the number of respondents selected for the study was a true reflection of the population.

# KNUST



## CHAPTER FOUR

### 4.0 RESULTS

#### 4.1 Introduction

The findings of the study are presented in this chapter. They are based on the objectives of the study. In all 550 women were interviewed on the use of family planning in postpartum women in the Kumasi metropolis.



## 4.2 Socio-Demographic Characteristics of the study sample

### 4.2.1 Socio-demographic characteristics of the study sample

Majority of the women interviewed fell into the 20-29 years age group with the mean age being 28.9 years ( $SD = 5.2$ ). Christianity was the dominant religion. Most women (72.9%) were married while 1.3% admitted to being separated. A little over half (56.2%) of women had attained only primary/ basic education or were without formal education. Majority of the women had some form of employment with 64% being self-employed. As expected, the dominant ethnic group was Akan (69.8%).

**Table 4.1: Socio-demographic characteristics of the study sample**

Variables	Frequency (550)	Percentage (%)
<b>Age</b>		
< 20	20	3.6
20 – 29	305	55.5
30 – 39	208	37.8
40- 49	17	3.1
<i>Mean = 28.9, SD = 5.2</i>		
<b>Religion</b>		
Christianity	360	65.4
Islam	190	34.6
<b>Marital Status</b>		
Single	43	7.8

Married	401	72.9
Cohabiting	99	18.0
Separated	7	1.3
<b>Education level</b>		
No formal education	87	15.8
Primary	222	40.4
Secondary	196	35.6
Tertiary	45	8.2
<b>Employment status</b>		
Unemployed	113	21.6
Self-employed	352	64.0
Employed (public sector)	43	7.8
Employed (private sector)	42	7.6
<b>Ethnicity</b>		
Akan	384	69.8
Ewe	16	2.9
Ga	4	0.7
Hausa	94	17.1
Dagomba	52	9.4

Source: Field Data, 2014

#### ***4.2.2 Relationship between socio-demographic characteristics and postpartum FP use***

When we compared the study participants by postpartum family planning uptake, they differed in age, marital status, education and employment status. The women who did not take up family planning were more likely to be younger. Those who took up family planning were more likely to be better educated, married and employed.

# KNUST



**Table 4.2: Socio-demographic characteristics influencing postpartum family planning uptake**

Variable	Contraceptive Uptake		chi square (p-value) / F-test
	Use n=223 (%)	Non-use n =327 (%)	
<b>Age</b>			0.020 <sup>a</sup>
< 20	2 (0.9)	18 (5.5)	
20 – 29	127 (57.0)	178 (54.4)	
30 – 39	89 (39.9)	119 (36.4)	
40 - 49	5 (2.2)	12 (3.7)	
<b>Total</b>	223	327	
<b>Religion</b>			3.36 (0.067) <sup>b</sup>

Christianity	156 (70.0)	204 (62.4)	
Islam	67 (30.0)	123 (37.6)	
<b>Total</b>	223	327	
<b>Marital Status</b>			0.031 <sup>a</sup>
Single	17 (7.6)	26 (8.0)	
Married	176 (78.9)	225 (68.8)	
Cohabiting	28 (12.6)	71 (21.7)	
Separated	2 (0.9)	5 (1.5)	
<b>Total</b>	223	327	
<b>Education level</b>			12.54 (0.006) <sup>b</sup>
No formal education	35 (15.7)	52 (15.9)	
Primary	80 (35.9)	142 (43.4)	
Secondary	79 (35.4)	117 (35.8)	
Tertiary	29 (13.0)	16 (4.9)	
<b>Total</b>	223	327	
<b>Employment status</b>			21.54 (0.0001) <sup>b</sup>
Unemployed	33 (14.8)	80 (24.5)	
Self-employed	139 (62.3)	213 (65.1)	
Employed (public sector)	29 (13.0)	14 (4.3)	
Employed (private sector)	22 (9.9)	20 (6.1)	
<b>Total</b>	223	327	
<b>Ethnicity</b>			0.100 <sup>a</sup>
Akan	167 (74.9)	217 (66.4)	
Ewe	6 (2.7)	10 (3.1)	
Ga	3 (1.4)	1 (0.3)	
Hausa	30 (13.5)	64 (19.6)	
Dagomba	17 (7.6)	35 (10.7)	
<b>Total</b>	223	327	

Source: Field Data, 2014

**Notes:**

Statistical significance ( $p < 0.05$ )

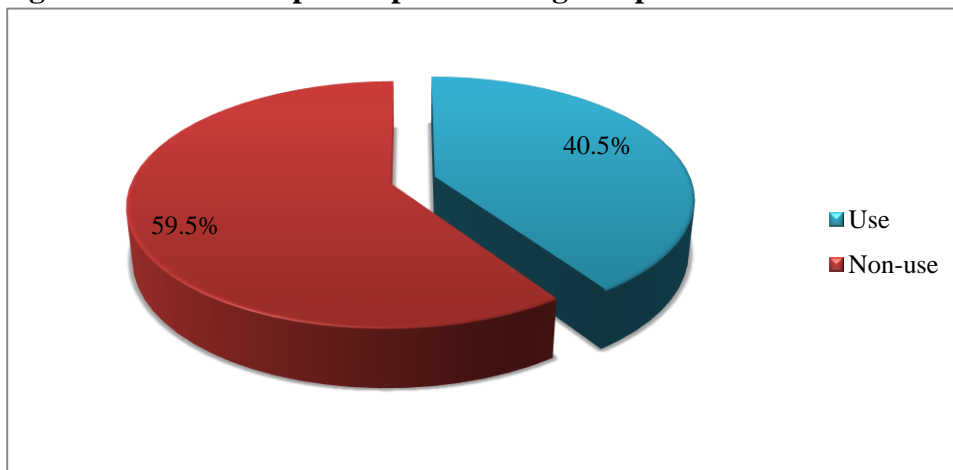
<sup>a</sup>Fisher's test (one-sided) <sup>b</sup>Chi square test

### 4.3 Contraceptive Use among Post Partum Women

#### 4.3.1 Prevalence of postpartum family planning

Less than half (40.5%) of the postpartum women interviewed were using family planning as of the time of the survey.

**Figure 4.1: Contraceptive Uptake among Postpartum Women**



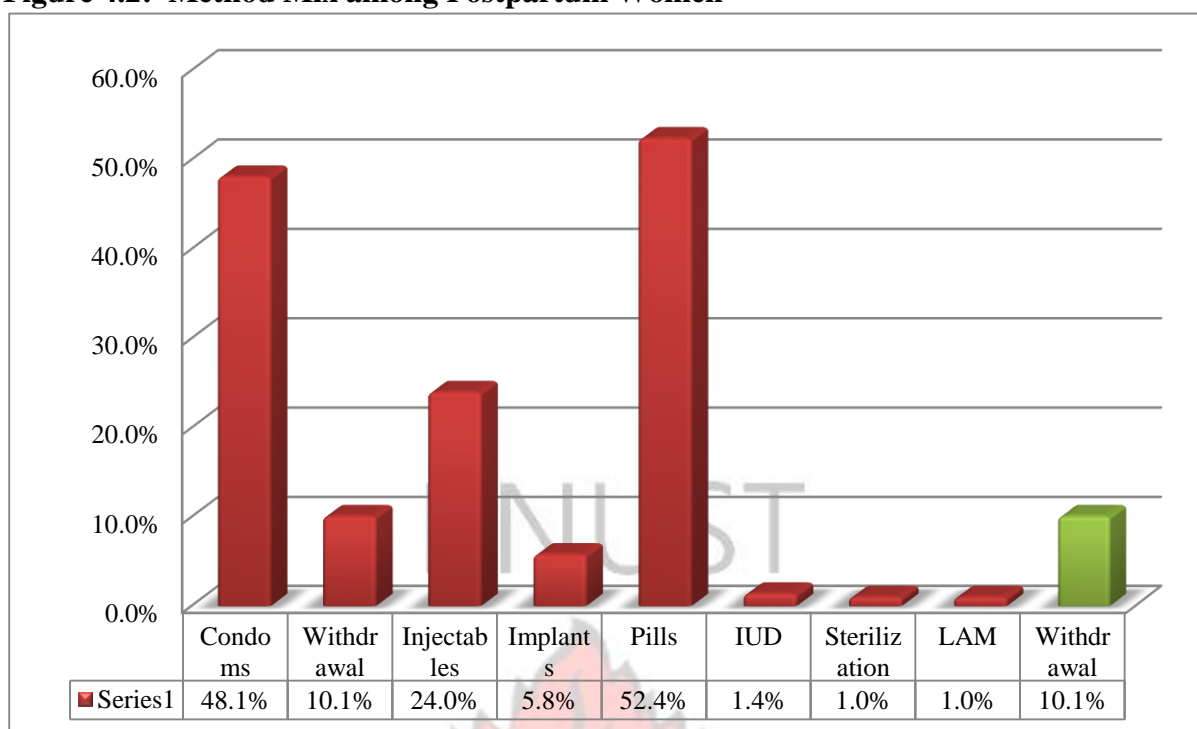
Source: Field Data, 2014

#### ***4.3.2 Method mix among postpartum women***

The main method used by women in the study was oral contraceptive pills (52.4%) followed by condoms (48.1%). The least utilized methods were sterilization and the lactational amenorrhoea method.



**Figure 4.2: Method Mix among Postpartum Women**



Source: Field Data, 2014

#### **4.4 Information about Postpartum Family Planning**

##### ***4.4.1 Relationship between being informed about family planning and postpartum use***

Almost all the users and non-users of family planning had received some information about family planning at some point in time. When asked if a woman who had recently delivered could use family planning, 83.4% of users and 77.6% of non-users responded in the affirmative. In addition, 45% of users and 36 % of non- users either disagreed or did not know that a woman could get pregnant soon after giving birth. The results further showed that having information about family planning and awareness of susceptibility to pregnancy both influenced postpartum family planning uptake.



**Table 4.3: Relationship between being informed about family planning and postpartum uptake**

Variable	Contraceptive Uptake		chi square (p-value) / F-test	Odds ratio (95% CI)
	Use n=223 (%)	Non-use n =327 (%)		
<b>FP awareness</b>			<b>0.034</b>	
Yes	216 (97.3)	305 (93.6)		1.0
No	6 (2.7)	21 (6.4)		0.40 (0.02– 1.02)
<b>Total</b>	<b>222</b>	<b>326</b>		
<b>Can a recently delivered woman use FP?</b>			<b>2.60 (0.107)</b>	
Yes	176 (83.4)	236 (77.6)		-
No	35 (16.6)	68 (22.4)		-
<b>Total</b>	<b>211</b>	<b>304</b>		
<b>Is it possible to get pregnant soon after delivery?</b>			<b>6.07 (0.048)</b>	
Yes	117 (54.2)	199 (63.4)		1.0
No	54 (25.0)	53 (16.9)		1.73(1.11 – 2.69)*
Don't know	45 (20.8)	62 (19.8)		1.23 (0.79 – 1.93)
<b>Total</b>	<b>216</b>	<b>314</b>		

Source: Field Data, 2014

**Notes:**

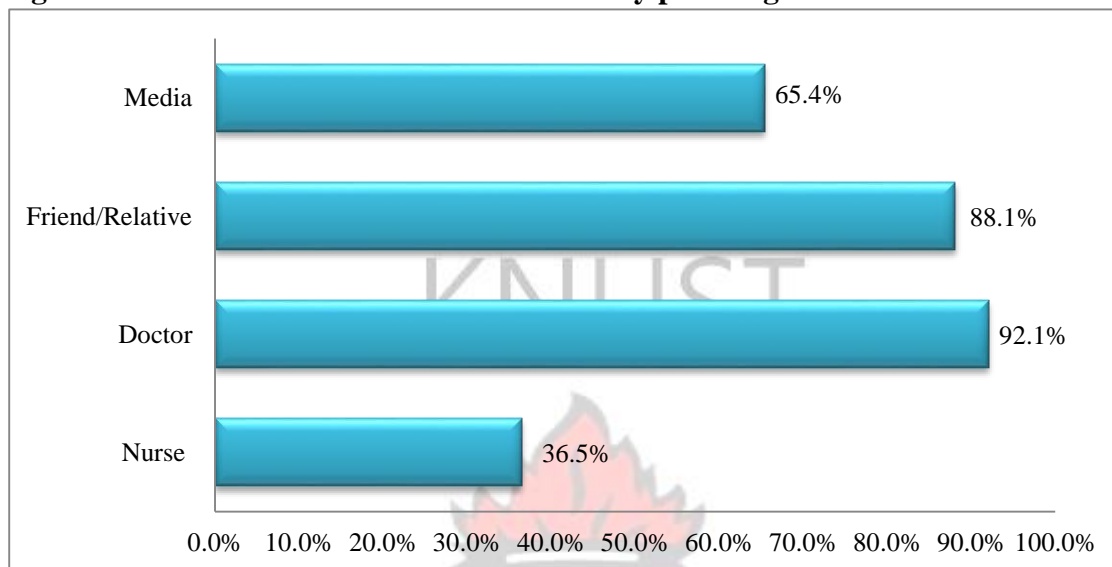
\*Indicates significance at  $p < 0.05$

**4.4.2 Source of information about family planning**

In most cases, women received information on family planning from more than one source. Doctors were shown to be the main source of information on postpartum family planning (92.1%) while 36.5% mentioned nurses as their source of information. Friends

and relatives also played a major role with about 88% citing them as their source of information.

**Figure 4.3: Source of information about family planning**

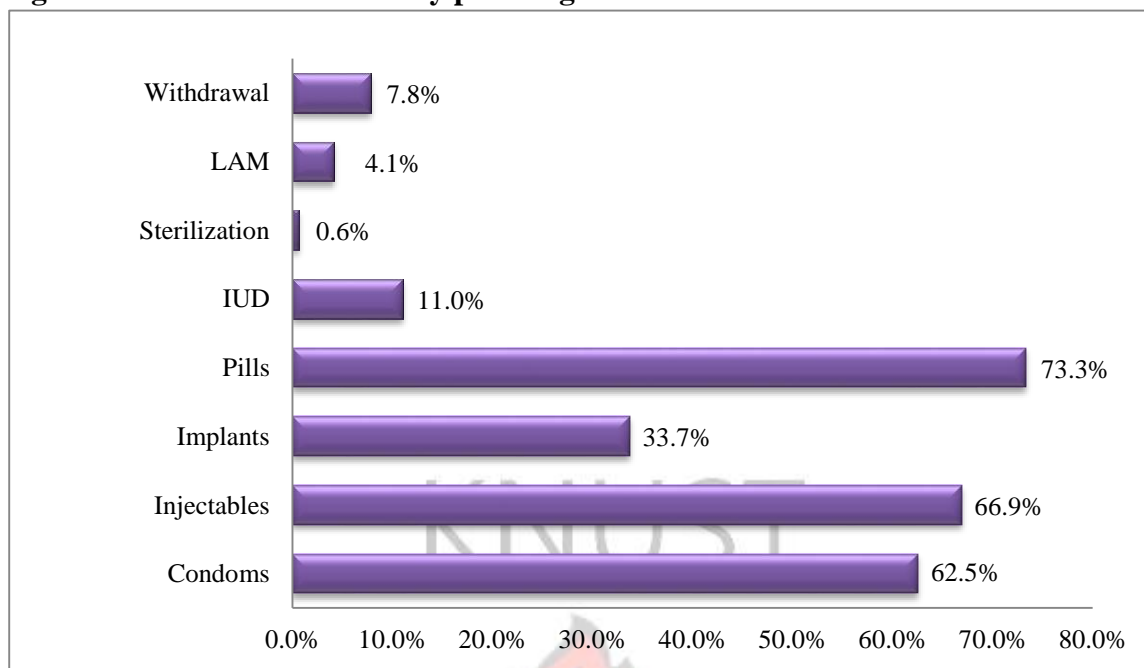


Source: Field Data, 2014

#### ***4.4.3 Awareness of family planning methods***

Respondents were aware of most of the family planning methods that were available. Majority of the women knew of methods such as the oral contraceptive pills (73.3%), injectables (66.9%) and condoms (62.5%). Few however were aware of or had heard of sterilization (0.6%), withdrawal (7.8%) or lactation amenorrhoea method (4.1%).

**Figure 4.4: Awareness of family planning methods**

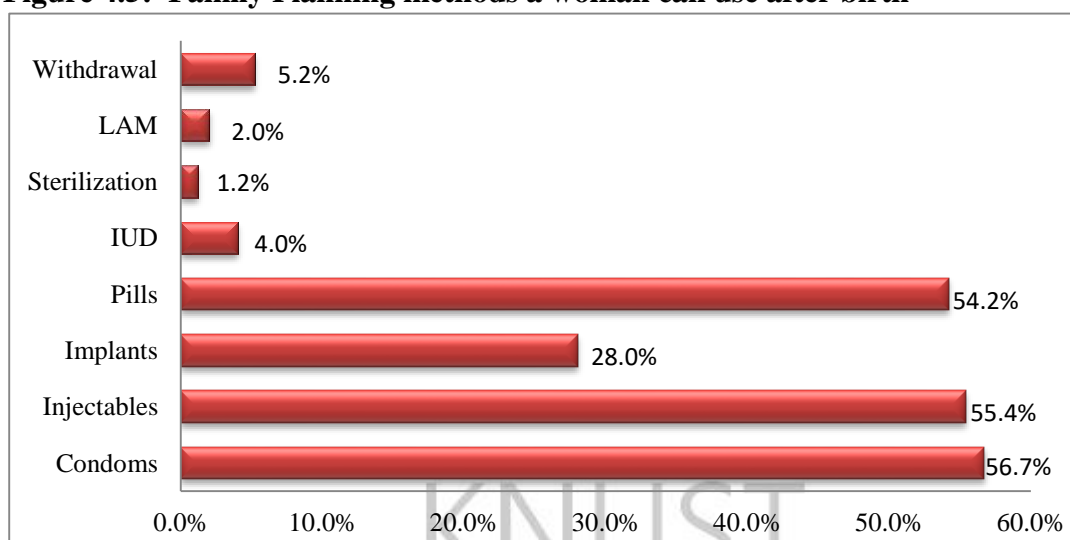


Source: Field Data, 2014

#### ***4.4.4 Family planning methods for postpartum use***

More than 50% mentioned condoms, oral contraceptive pills and injectables with less than 5% mentioning intrauterine contraceptive devices, sterilization and lactation amenorrhea as family planning methods that can be used after delivery.

**Figure 4.5: Family Planning methods a woman can use after birth**



*Source:* Field Data, 2014

#### **4.5 Relationship between accessibility of service and postpartum family planning use**

For more than half of women who practiced postpartum contraception, the service was located within the hospital premises. Less than 15% reported the service being either close to or far from the hospital premises. Almost 70% of users of postpartum family planning commuted via public transport to the services, 19.7% went by foot, while 12.1% had access to private means of transport. About 90% of users found the cost of transportation cheap or affordable. In about 90% of the users, they did not have to travel long distances from their places of residence to the service providers. Slightly more than half of the users of family planning paid for the use of services and in most cases, the desired methods were available. In 97% of users, women understood the language that providers used for communication.

**Table 4.4: Relationship between accessibility of service and postpartum family planning use**

Variable	Contraceptive Use n=223 (%)	
	Frequency	Percentage (%)
<b>FP service location</b>		
Within hospital premises	162	72.6
Close to hospital	28	12.6
Far from hospital	33	14.8
<b>Total</b>	223	100
<b>Means of transport to health facility</b>		
By foot	44	19.7
By public transport	152	68.2
By private transport	27	12.1
<b>Total</b>	223	100
<b>Cost of transport</b>		
Cheap	36	18.2
Affordable	142	71.7
Expensive	19	9.6
Very expensive	1	0.5
<b>Total</b>	198	100
<b>Long distance from FP service to residence</b>		
Yes	23	10.4
No	199	89.6
<b>Total</b>	222	100
<b>Payment for family planning services</b>		
Yes	125	56.1
No	98	43.9
<b>Total</b>	223	100
<b>Understanding of language used at FP clinics</b>		
Yes	207	97.2
No	6	2.8
<b>Total</b>	213	100
<b>Availability of FP methods</b>		
Yes	177	85.5
No	30	14.5
<b>Total</b>	207	100

Source: Field Data, 2014

#### **4.6 Relationship between quality of family planning services and postpartum use**

More than 80% of users of postpartum family planning described the receptions of family planning clinics as private and to their satisfaction. For more than 78% of users there was a short waiting-time before being attended to; 89% of users said the services

provided met their expectations. Over 80% of users said service providers were friendly and seemed up-to-date on issues of family planning. More than 60% of family planning users reported being informed about the side effects of the methods. Over 50% of users said they would return to their service providers while 86.3% said they would refer a friend or relative to their service provider.

**Table 4.5: Relationship between quality of family planning services and postpartum use**

Variable	Contraceptive Use n=223 (%)	
	Frequency	Percentage (%)
<b>Reception (privacy &amp; satisfaction)</b>		
Yes	153	82.7
No	32	17.3
<b>Total</b>	185	100
<b>Long waiting time</b>		
Yes	45	21.3
No	166	78.7
<b>Total</b>	211	100
<b>FP service provision (satisfactory)</b>		
Yes	188	89.1
No	23	10.9
<b>Total</b>	211	100
<b>Attitude of FP provider</b>		
Friendly and up-to-date on FP issues	175	82.2
Indifferent	38	17.8
<b>Total</b>	211	100
<b>Informed about side effects of method</b>		
Yes	135	65.5
No	71	34.5
<b>Total</b>	206	100
<b>Will return to FP service provider</b>		
Yes	178	62.8
No	105	37.1
<b>Total</b>	283	100
<b>Will refer relative/friend to provider/ facility</b>		
Yes	182	86.3
No	29	13.7
<b>Total</b>	211	100

*Source:* Field Data, 2014



#### **4.7 Relationship between partner-support and postpartum family planning use**

Approximately 80% of postpartum users of family planning had discussed family planning with their partners and 81.9% of users said their partners were willing to or did provide financial assistance in accessing family planning services. Only 36% of non-users said their partners would be willing to provide financial assistance to access family planning services. Over 60% of users felt that their partners knew of and approved the use of family planning with barely 35% responding otherwise. Majority (81.9%) of women using postpartum family planning felt that the final decision about whether or not to use family planning should be made by the couple while 5.2% said it was the man's decision. Discussing family planning with one's partner ( $p=0.0001$ ), financial assistance from one's partner for family planning ( $p=0.0001$ ) and decision-making about family planning use ( $p=0.014$ ) were statistically significant in the postpartum uptake of family planning.



**Table 4.6: Bivariate analysis: relationship between partner-support and postpartum family planning use**

Variable	Contraceptive Uptake		chi square test (p-value)
	Use n=223 (%)	Non-use n=327 (%)	
<b>Discussion of FP with partner (n=509)</b>			117 (0.0001)
Yes	171 (79.5)	91 (30.9)	
No	44 (20.5)	203 (69.1)	
<b>Total</b>	215	294	
<b>Financial assistance from partner for FP (n=488)</b>			102.31 (0.0001)
Yes	172 (81.9)	100 (36.0)	
No	38 (18.1)	178 (64.0)	
<b>Total</b>	210	278	
<b>Partner approves of FP use (n=490)</b>			1.93 (0.165)
Yes	136 (65.4)	167 (59.2)	
No	72 (34.6)	115 (40.8)	
<b>Total</b>	208	282	
<b>Decision- making about FP use (n=442)</b>			8.56 (0.014)
Self	27 (12.9)	37 (15.9)	
Partner	11(5.2)	29 (12.5)	
Both	172 (81.9)	167 (71.7)	
<b>Total</b>	210	233	

Source: Field Data, 2014

#### **4.8: Factors Influencing Postpartum Family Planning Uptake**

Multivariate logistic regression was conducted to determine whether the factors being examined influenced postpartum family planning uptake. Odds ratios were calculated for the variables and then adjustments were made to eliminate confounders.

##### **4.8.1 Socio- demographic factors influencing postpartum family planning use**

Age was shown to be significantly associated with postpartum family planning uptake. Women aged 20- 29 years were 6(six) times more likely to practice postpartum family planning compared with those aged below 20 years (OR=6.42; 95% CI=1.42- 28.12). The odds were 7 (seven) times higher for women aged 30-39 years (OR= 6.73; 95% CI=1.52- 29.76) while women who were between 40- 49 years were four times as likely to use postpartum family planning (OR= 3.75; 95% CI=0.62- 22.57). After adjusting for confounders, though the odds of uptake were increased for all women aged over 20 years, only those obtained for women aged 20- 29 years had statistical significance (AOR= 4.80; 95% CI= 1.06- 21.72).

Marital status of women was shown to have no significant association with postpartum family planning uptake even after adjusting for confounding variables.

Education was shown to have some influence on the uptake of postpartum family planning. The odds for postpartum family planning use were significantly higher in women who had attained tertiary level of education (OR=2.69; 95% CI= 1.28- 5.68). After adjusting for confounders, no significant association was found to exist between the education levels of women and their use of family planning in the postpartum period.

Employment status had some influence on the postpartum use of family planning. Women who were working in the public sector were 5(five) times more likely to use contraception after delivery compared to unemployed women (95% CI= 0.52-1.54). For those who worked in the private sector, the odds of uptake were almost 3(three) times higher with reference to unemployed women (OR= 2.67; 95% CI= 0.58- 3.38). In both cases, the odds were statistically significant. After adjusting for confounders, the odds of uptake were still higher for women working in both the public and private sectors, though they were not statistically significant (AOR= 3.47 and 2.20).

respectively).

Analysis of the results showed that the observed counts and those predicted by the model are close ( $p = 0.9585$ ) therefore the model describes the data well.

**Table 4.7: Unadjusted and adjusted effects of socio-demographic factors on postpartum contraceptive uptake**

Variable	Unadjusted		Adjusted	
	OR	95% CI	OR	95% CI
<b>Age</b>				
< 20	1.0		1.0	
20 – 29	6.42	1.42 – 28.12	4.80	(1.06 – 21.72)*
30 – 39	6.73	1.52 – 29.76	4.60	1.0 – 21.21
40 - 49	3.75	0.62 – 22.57	2.93	0.47 – 18.26
<b>Marital Status</b>				
Single	1.0		1.0	
Married	1.20	0.63 – 2.27	0.89	0.43 – 1.81
Cohabiting	0.60	0.28 – 1.28	0.49	0.21 – 1.11
Separated	0.61	0.11 – 3.52	0.42	0.07 – 2.57
<b>Education level</b>				
No formal education	1.0		1.0	
Primary	0.84	0.50 – 1.39	0.86	0.51 – 1.46
Secondary	1.00	0.60 – 1.68	0.85	0.50 – 1.48
Tertiary	2.69	(1.28 – 5.68)**	1.36	0.56 – 3.29
<b>Employment status</b>				
Unemployed	1.0		1.0	
Self-employed	1.58	1.00 – 2.50	1.44	0.88 2.34
Employed (public sector)	5.02	(2.36 – 10.69)***	3.47	1.45 – 8.31
Employed (private sector)	2.67	(1.29 – 5.53)**	2.20	0.99 – 4.88
			<b>Hosmer-Lemeshow (H-L) Test</b>	
			H-L = 2.57	
			P-value = 0.9585	

\*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$  RC =Reference category

#### **4.8.2 The influence of partner- support on postpartum family planning use**

Lack of communication with partners about family planning was shown to significantly reduce the odds of using it in the postpartum period (OR=0.11; 95% CI=0.08-0.17) and

this was reinforced by the adjusted odds ratio obtained (AOR=0.21; 95% CI= 0.1236).- 0.

Additionally, financial assistance from partners for family planning was significantly associated with uptake. Where there was no financial assistance, the odds of utilization was greatly reduced (OR=0.12; 95% CI=0.08- 0.19: AOR=0.20; 95% CI= 0.11-0.35).

Decision- making about using postpartum family was shown to influence family planning use in the postpartum period. The odds were reduced to 0.52 (95% CI=0.22-1.22) when the decision to use family planning was made by the partner with the woman as the reference category. It increased to 1.41 (95% CI=0.82- 2.42) when the decision was made by the couple. Adjusting for confounders brought the odds for uptake to 0.21 (95% CI=0.07-0.59) when the partner took the decision and 0.35 (95% CI=0.17-0.71) when it was taken by the couple. For variables related to partner support, however, the observed counts and those predicted by the model were not close (0.0143) hence a poor description of the data by the model.

**Table 4.8: Unadjusted and adjusted effects of partner influence on postpartum contraceptive uptake**

Variable	Unadjusted		Adjusted	
	OR	95% CI	AOR	95% CI
<b>Discussion of FP with partner</b>				
Yes (RC)	1.0		1.0	
No	0.11	(0.08–0.17)***	0.21	(0.12–0.36)***
<b>Receive FP financial assistance from partner</b>				
Yes (RC)	1.0		1.0	
No	0.12	(0.08–0.19)***	0.20	(0.11–0.35)***
<b>Final decision about FP use</b>				
Self (RC)	1.0		1.0	
Partner	0.52	0.22 – 1.22	0.21	(0.07 – 0.59)**
Both	1.41	0.82 – 2.42	0.35	(0.17 – 0.71)**
		<b>Hosmer-Lemeshow (H-L) Test</b> H-L = 12.45 P-value = 0.0143		

**\*p < 0.05, \*\*p < 0.01, \*\*\*p < 0.001 RC =Reference category Source:**  
Field Data, 2014

## **CHAPTER FIVE**

### **5.0 DISCUSSION**

#### **5.1 Introduction**

In this chapter, the findings of the study were closely scrutinized based on the objectives. Comparisons were made to literature from previous studies in order to determine reasons for specific trends and patterns.

Postpartum family planning is vital because of the role it plays in the prevention of unwanted pregnancies soon after delivery. As a result, women can have their babies when they so desire leading to a reduction in the rate of unsafe abortions and the maternal deaths that are usually associated with it. The World Health Organization in 2006 recommended that the interval before attempting the next pregnancy after a live birth, should be at least 24 months and in the case of an abortion or miscarriage, 6 months (WHO, 2006). This is aimed at reducing the risk of adverse maternal, perinatal and infant outcomes.

This cross-sectional study conducted in the Kumasi metropolitan area sought to determine the prevalence of postpartum family planning and explore the determinants of its uptake.

#### **5.2 Prevalence of postpartum contraception in the Kumasi metropolis**

High postpartum family planning will lead to healthy birth intervals which will profoundly impact maternal and neonatal health outcomes culminating in long-term societal and economic benefits.



Out of the 550 women within the 12-month postpartum period who were interviewed, only 223 representing 40.5% of respondents practiced a form of family planning. This compares with the findings of Mathe et al (2011) who reported a rate of 44% postpartum family planning uptake in Butembo in the Eastern province of the Democratic Republic of Congo. It is however higher than the uptake of 33% recorded in Zambia, by Ross & Winfrey (2001) and far lower than that of Indonesia, 75% (Gebreselassie, Rutstein & Mishra, 2008). The result obtained is also higher than the uptake among the general Ghanaian population of 24% for currently married women within the reproductive age-group. Several reasons were given by the women, in this study, for not practicing family planning and these may account for the low uptake. They included the fear of side effects of contraceptives, religious or cultural beliefs that it was wrong and the fear of sterility in male partners .

The commonest form of contraception adopted by postpartum women in this study was the oral contraceptive pills followed by the condom and then the injectables. This is consistent with findings from studies in the Dominican Republic where the pill was shown to be the dominant method of contraception after birth in 43% of women (Gebreselassie, Rutstein & Mishra, 2008). In many cases of this study, there was an overlap of methods used for contraception. Pills were used in many instances with condoms. The adoption of pills and condoms mainly, by the women in this study, may be attributed to their ready availability in the pharmacies or chemical shops (GSS/GHS/ICF Macro, 2009) even if the health facilities do not have them. Using them together, however may be because some women are not judicious in their use of the pills and fearing that they might get pregnant, would rather add the condom as a back-up plan.

### **5.3 Factors influencing the uptake of postpartum family planning in the Kumasi Metropolis**

Results obtained from this study showed association between some of the factors being studied and postpartum family planning use. Using findings from other studies, attempts were made to decipher what may account for these findings.

#### ***5.3.1 Socio- demographic factors influencing postpartum family planning use***

According to the study, age was shown to significantly influence postpartum family planning use. As age increased, there was a concomitant increase in uptake. Even after adjusting for covariates, the odds for use were almost 5 times for women aged 20-29 years and those aged 30-39 years; compared to women less than 20 years of age. From 40- 49 years however, the odds of uptake dropped slightly to 3. This is similar to findings from the 2007 Ghana Maternal Health Survey where current contraceptive use was shown to vary with age. Uptake was lowest among married women aged 15-19 years and highest among those aged 35-39 years. Between 20-29 years, most women in Ghana would be getting married and starting their families; this may also be the case for some women aged 30-39 years. Within this same range however, the desire to have children may start diminishing for some women as they would be focusing on how to care for the ones they already have. Beyond 40 years, women feel that they are less likely to conceive. This, in addition to probably having fewer sexual encounters, would be inadequate motivation for them to practice postpartum family planning.

Marital status of respondents was shown to have no significant influence on postpartum family planning use. This is a rather contrary finding as being in noncommitted relationships might encourage women to resort to postpartum contraception. Due to the absence of a binding agreement, some women may feel that their partners would refuse

to provide support for children that may result from such a relationship and this fear may be enough incentive for such women to use postpartum family planning.

A woman's level of education was shown, in the study, to have no significant association with postpartum contraceptive use after adjusting for confounders. This contradicts results from the 2007 Maternal Health Survey where current use of a modern form of contraception rose from 10% among women with no education, to 17% among women with at least secondary level of education. It was expected that highly educated women who tend to have more goals and aspirations would have a greater desire to use contraception after birth however this was not the case. A possible explanation may be the fact that women with higher education end up marrying and starting their families much later than those with a lower level of education. The limited time available and issues of decreased fecundity may therefore make them more reluctant to use postpartum contraception because they will be trying to have the number of children they so desire in the shortest possible time.

Another surprising outcome was the lack of significant association between employment status and postpartum family planning use. Prior to adjustment for confounders however, women who worked in the public and private sector had increased odds of postpartum contraception; 5 and approximately 3 times respectively, compared to unemployed women. This trend may be attributed to the financial independence associated with being employed, making them less reliant on their partners for financial assistance in obtaining contraceptives.

### ***5.3.2 How informed postpartum women are about family planning***

Acquisition of knowledge about family planning is a significant step in the quest to gain access to family planning services and eventually adopt a method of contraception.

Awareness of family planning was associated with postpartum uptake ( $p=0.034$ ). Generally, there was a high level of awareness of family planning. Over 90% of women (users and non-users) had some information however, the level of family planning use was low (40.5%). This high awareness, low usage disparity was also noticed in the study conducted by Mathe, Kasonia and Maliro (2011) in Butembo- DRC. The odds for use were noticed to be reduced to 40% for women with no awareness compared to women who had some awareness. It may be argued that women who have not received any education about family planning during ANC or postnatal visits are unlikely to utilize the service as a result of ignorance. In Senegal, it was observed that over two-thirds of women who delivered in health facilities did not receive any information on family planning either before or after delivery whiles at the facility (Speizer et al., 2011). Naanyu et al.(2013) also observed in Kenya that the majority of postpartum women who did not use family planning had never had the opportunity to interact with a healthcare provider on the topic. For women who had received some information about family planning however, the reason for non- use may be inadequate and/or inappropriate information.

The study revealed that most women had more than one source of information on family planning. The doctor was cited as the main source, followed by friends/ relatives and then nurses/ midwives. This finding differs from the one obtained in

Butembo where the commonest sources of information were friends (50%), nurses (32%) and school (14%). Only 3% gave doctors as their source of information (Mathe, Kasonia and Maliro, 2011). It is unclear how this result came to be because in most developing countries, the disproportionate doctor- patient ratio makes it difficult for them to have enough time to properly counsel the numerous clients about family planning. Also in Burkina Faso, according to postnatal care guidelines, although women

are supposed to receive family planning advice throughout the postpartum period, providers tend to focus on the sixth week (Daniele M, 2014).

Information on return to fertility after pregnancy was shown to be associated with postpartum family planning uptake ( $p=0.048$ ). About 30% of women did not know that a woman is susceptible to pregnancy after birth before the resumption of her menses. Earlier studies in sub-Saharan Africa similarly showed that women and their health providers are unaware of the return to fertility after birth. They therefore use the resumption of menses as a cue for the adoption of contraception (Adeyemi et al., 2005, Borda et al., 2011). The odds for uptake were however revealed to be 73% higher for women who had no knowledge about return to fertility prior to resumption of menses compared to women who had this knowledge. The lack of knowledge about postpartum susceptibility to pregnancy by such an appreciable number of women may be attributed to the fact that they have not been informed as already stated above.

There was limited knowledge of the family planning methods that are available. A relatively high proportion of women were aware of modern methods such as the pill, injectables and condoms however, there was a low awareness of others like implants, intrauterine contraceptive devices and sterilization. Of great interest was the fact that natural methods like withdrawal and lactation amenorrhea were also not well known (7.8% and 4.1% respectively). This finding is consistent with studies in Haiti which revealed that practically all women had heard about condoms, pills and injectables however, very few of them knew about methods such as sterilization and the use of implants (Cayemittes et al., 2007).

Most of the women who participated in the study (users and non-users) were aware of the fact that a woman could adopt a form of family planning soon after delivery. They were questioned about family planning methods that could be used post-delivery, but the responses obtained confirmed that women were not adequately informed about



postpartum contraception. Slightly more than 50% mentioned the condoms, injectables and pills; less than 30% mentioned implants and less than 10% mentioned IUCD, sterilization, withdrawal and LAM. Poor knowledge of the postpartum contraceptives may be due to the fact that providers do not talk much about them. This finding is again consistent with what was observed in Burkina Faso where the lack of promotion of certain methods by healthcare providers due to low patronage by clients was cited as one of the reasons for reduced awareness. Furthermore, some providers were found to be biased towards some methods due to personal opinions, experiences and religious beliefs (Daniele M, 2014). Consequently, they may be unwilling to give information about such methods to their clients.

### ***5.3.3 The Relationship between Accessibility of services and postpartum family planning uptake***

The ease with which a woman who has recently delivered can reach her health provider and access her healthcare needs goes a long way to influence whether she will utilize the services available.

Accessibility of family planning services was shown to have some relationship with uptake in postpartum women. For the majority of respondents practicing postpartum family planning, the services were located within the hospital premises (72.6%). This observation may be due to the fact that postpartum women prefer the convenience of being able to receive treatment for ill health and meeting their family planning needs in the same locality without having to move around too much.

The ability to commute from home to the service provider with ease plays a significant role in its utilization. Most users of postpartum family planning travelled via public transport to their service providers with only 12% having access to private transport. With relatively easy access to public transport within the Kumasi metropolitan area



women will be able to reach family planning centers easily, making travelling with a baby, less taxing and frustrating.

Transportation cost for most women using postpartum family planning in this study, was deemed affordable and in some cases, cheap. This may be attributed to the fact that about 76% of them had some form of employment making it possible for them to pay for the transport fare to and from the clinic.

Majority of the users of postpartum family planning reported that they did not have to travel long distances to reach the services. Having to travel a short distance to the clinic, especially when it has to be done with a baby in tow, makes for easy movement and may act as a strong motivation for women to avail themselves of the services. Studies by Okech et al. (2011), in Kenya revealed that the farther family planning services were from the clients, the less likely women were to utilize them. The reason given for this outcome was that, the longer the distance from the service provider, the higher the cost of transportation and transaction as well as longer waiting and travelling times (Okech, Wawire and Mburu, 2011).

Slightly more than 50% of women using postpartum contraception reported that they had to pay for the use of family planning services while the remaining 43.9% did not have to make any payment. This finding was a deviation from what was expected as most people would be reluctant to make use of services they have to pay for. A possible explanation could be that the women believe that the quality of service will be sub-standard if they do not paying anything. Conversely, since the cost of utilization is generally affordable and majority of the women in this study have some form of employment or financial independence, they can afford to pay for the services at the family planning clinics. Thus making payment or otherwise may not have any relationship with utilization of postpartum family planning.

Understanding of the language used to communicate at family planning clinics was almost universal for family planning users in the study. This may be related to postpartum uptake because when potential users are able to grasp what is communicated to them at the counseling sessions, they are able to communicate with their partners about the information they have received and have clarity of mind to make informed choices.

Over 85% of users reported that their contraceptive method of choice was readily available at clinics compared to 14.5% who did not have ready availability of preferred methods at their clinics. Having the preferred method of contraception whenever a client visits the family planning clinic tends to serve as motivation to continue practicing contraception, thereby reducing client dissatisfaction which may result in contraceptive discontinuation. This is in consistent with findings by Daniele (2014) from her studies in Burkina Faso where it was discovered that during certain months, there was a shortage of implants in certain regions. Whenever this happened and clients were offered other methods which they did not want, the number of users invariably reduced.

#### ***5.3.4: The relationship between Quality of care and postpartum family planning use***

The environment in which counseling sessions are held plays a vital role in determining whether or not women will utilize family planning services. The quality of care at family planning centers was found to have some relation with the postpartum uptake.

Most women who used postpartum family planning found the clinic environment private and welcoming (82.7% v 17.3%). For such women, there was a waiting area available to them and some privacy was ensured so they could access the service comfortably. The ability to ensure privacy at the clinics will enable clients to relax and discuss the intimate details of contraception without worrying that they will be

overhead. Privacy at the family planning clinic may therefore have some relationship with utilization of the service.

Waiting time at family planning clinics was also related to postpartum use. 78.7% of women using contraception had a short waiting time at the clinics compared with 21.3% who had to wait for long before being attended to. A short waiting-period at the family planning clinic implies that when clients visit, they are quickly attended to without having to spend the whole day there. They therefore have plenty of time to attend to other pertinent issues. It may be explained that the frequent training sessions and workshops being organized for health-care providers, have led to a better understanding of how to relate to the clients visiting the clinic thereby ensuring promptness in the provision of care.

Majority of the users of postpartum contraception were satisfied with the service delivery at clinics. This may be attributed to their expectations for the family planning clinics being met by the service providers. Further buttressing this finding is the fact that most users had positive interactions with the service providers. Most postpartum contraceptive users (82.2%) found providers to be friendly and up to date on issues related to family planning. This finding is consistent with what was observed in Kenya where the use of family planning services were 19% higher when service providers were friendly compared to when they were not (Okech, Wawire & Mburu, 2011). When service providers relate in a friendly and respectable manner towards clients, it creates good rapport and makes them more receptive to the information being given; making clients more willing to return to the clinic.

Information about possible side effects of contraceptives was relayed to a large proportion of women before they commenced use. It may be explained that when women are adequately informed about the possible side effects of contraceptives, they

are better prepared when they begin to use them and are not taken unawares when these side effects occur. However, when no information is given about possible side effects, clients sometimes feel like the method is not suitable for them and instead of returning to the provider, they go ahead and discontinue its use. Being informed about possible side effects of contraception may thus have some relation to uptake.

A few ways of measuring quality of service include whether or not clients will return to their service providers and whether or not they would be willing to refer someone, a friend or relative, to the provider. Most of the respondents said they would like to return to their service providers as opposed to a few who said otherwise (83.2% versus 16.8%). Again, majority (86.3%) of the users said they would be willing to refer a relative or friend to their service provider while a few (13.7%) said they would not. This finding is a clear indication of how clients respond to the quality of services that are rendered to them. When women visit the family planning clinics and their expectations are met, they will most likely return to utilize the service. Verbal commendation remains one of the most efficient ways of promoting a product or service, therefore when a person makes a negative report, most people would not even bother to verify the report before rejecting it outright.

#### ***5.3.5: The influence of partner support on postpartum family planning use***

Partner support was shown to play a major role in the use of postpartum family planning. Communicating with partners about postpartum family planning was strongly associated with its uptake ( $p=0.0001$ ). Majority of the contraceptive users had had some discussions with their partners (79.5% versus 20.5%). For the non- users however, only a small proportion had had any discussions with their partners (30.9% versus 69.1%).

The odds for uptake were markedly low in women who had had no communication with their partners about family planning compared to women who had communicated with their partners (AOR=0.21, 95% CI=0.12- 0.36). This is consistent with the report by Toure, (1996) which notes there being a positive association between spousal communication and the utilization of a family planning method.

Receiving financial assistance in order to access family planning services was significantly associated with postpartum uptake. 81.9% of users said their partners were willing and did financially assist them to obtain contraceptives as opposed to 18.1% who reported otherwise. This differs dramatically from what was observed in Burkina Faso by Daniele (2014) where husbands perceived contraception as not being urgent thereby unwilling to give money to their women to pay for a method. The odds for uptake were reduced when no financial assistance from partners was forthcoming (AOR=0.20, 95% CI= 0.11-0.35). Women who receive financial support tend to feel economically empowered and are more confident should they encounter situations where they have to pay for their contraceptives.

How one's partners feels about contraception is a major determinant of whether or not women would use it in the postpartum period. 65.4% of users stated that their partners approved of their decision to use contraceptives. Results from the study however, revealed no significant association between a partner's approval and postpartum use ( $p=0.165$ ). This finding is inconsistent with studies by Okech et. al (2011) in Kenya where partner support was revealed to be the most important determinant of family planning utilization. Though men hold the position of power in most African homes and women would not want to antagonize their partners or do anything that would jeopardise the security of their marriages or relationships, increase in education, employment and female empowerment has resulted in women becoming more



proactive and taking decisions that will be beneficial to them and their families even if their partners do not necessarily approve.

Uptake of postpartum family planning was influenced by the person who made the final decision about whether or not to use it ( $p=0.014$ ). For the majority of users (81.9%), the final decision about postpartum family planning use was taken by the couple as opposed to 12.9% where the women themselves took the final decision. The odds for uptake were observed to be low when the man or the couple made the final decision (AOR=0.21, 95% CI=0.07- 0.59 and AOR=0.35, 95% CI= 0.17-0.71 respectively) compared to when the final decision fell to the woman. This finding may be explained by the fact when women feel in control of their bodies and are allowed to make important decisions regarding it, they are more likely to choose options that would be most beneficial to them and in the long run, their families.

## **CHAPTER SIX**

### **6.0 CONCLUSIONS AND RECOMMENDATIONS**

This chapter presents the conclusions of the study based on the significant findings and goes on to make recommendations which will enable further studies and help with the development of national policies.

#### **6.1: Conclusions**

##### ***6.1.1: The prevalence of postpartum family planning in the Kumasi metropolis***

According to the results obtained from this study, the prevalence of postpartum contraception in the Kumasi metropolis was not optimal. Out of 550 women who were interviewed, only 40.5% practiced some form of postpartum family planning. Oral contraceptive pills were the most widely used method of contraception (52.4%)



followed by condoms and then injectables. Very few women practiced sterilization, lactation amenorrhea or withdrawal methods of family planning.

### ***6.1.2 Factors influencing postpartum family planning uptake***

Demographic variables such as age, marital status, education level and employment status were significantly associated with postpartum family planning uptake while religion and ethnicity showed no association at the bi-variate level of analysis. At the multivariate level however, only age was shown to have an influence on uptake.

Awareness of family planning was associated with postpartum uptake at the bivariate and multivariate levels of analysis. Majority of women were generally informed about family planning. In most cases, this information was obtained from more than one source with the doctor being cited as the main source (92.1%) closely followed by relatives/ friends. An appreciable proportion of respondents had no knowledge about a woman's susceptibility to pregnancy after delivery and this was attributed to the fact that they had not been informed. There were varying degrees of awareness of the various contraceptive methods. Modern methods like oral contraceptive pills, injectables and were well-known while others like implants, intra-uterine devices and sterilization were poorly known. Additionally, women were not well informed about natural methods like withdrawal and lactation amenorrhea methods. Respondents had limited information about contraceptive methods that could be employed postpartum. Pills, injectables and condoms were mentioned by approximately 50% of respondents while less than 30% knew about intrauterine devices, implants, sterilization LAM and withdrawal methods.

Accessibility of family planning services was observed to have some relation with postpartum family planning uptake. For most respondents using contraception, the

location of family planning services, cost of transportation, means of transport to health services, distance from residence to health services, understanding of the language used for counseling sessions and the availability of preferred family planning methods were shown to play roles in postpartum uptake.

The quality of family planning services was also related to postpartum uptake. Privacy at clinics, waiting time, service provision, being informed about the sideeffects of family planning methods and willingness to return to service providers and to recommend services to friends and family were all vital to the quality of services clients expected at clinics in order to use the services.

Partner support was significantly associated with postpartum family planning uptake. Discussing family planning with one's partner, receiving financial assistance from one's partner and decision- making about the use of family planning were shown to significantly influence postpartum uptake.

## **6.2 Recommendations**

Based upon the findings of this study, the following recommendations are hereby proposed to improve family planning uptake in postpartum women.

### **MOH/MOE**

□ Ministries of Health and Education should collaborate with Non-governmental organizations to intensify education of women in the metropolis on postpartum family planning. This effort is vital as women seem uninformed about the family planning methods and issues regarding susceptibility to pregnancy after delivery. When this is done, it will ensure that women become more aware of their fertility and hence make appropriate decisions regarding pregnancy and future family sizes.

## **Metropolitan Health Directorate**

- There must be a regular supply of a complete method mix within the metropolis. This will ensure that methods are constantly available at the clinic and women can choose.
- Training programmes should be organized for service providers with regular evaluation sessions to make sure they are adequately informed before they go back to their clients.

## **Health Facilities**

- Women who deliver at health facilities, as a rule, should be educated and offered a family planning method on delivery and/or at postnatal clinics.
- Information about side-effects of methods should be provided and clients should be encouraged to return to providers to discuss the way forward in case they occur.
- Incentives and award-systems should be instituted by facilities to encourage staff to provide good quality service to clients.

## **Further research**

- Further research should be conducted using qualitative methods to ascertain the reasons behind low postpartum family planning uptake.
- Studies must also be conducted to determine whether the integration of family planning into other services has improved the uptake.

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## **APPENDICES**

### **APPENDIX A: QUESTIONNAIRE QUESTIONNAIRE FOR POSTPARTUM WOMEN**

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY/  
COLLEGE OF HEALTH SCIENCES/ SCHOOL OF MEDICAL SCIENCES/**

**DEPARTMENT OF COMMUNITY HEALTH**

**TOPIC: FACTORS INFLUENCING FAMILY PLANNING UPTAKE IN  
POSTPARTUM WOMEN IN THE KUMASI METROPOLIS**

DISTRICT/ METROPOLIS.....

SUB- DISTRICT/SUB-METROPOLITAN AREA.....

DATE OF INTERVIEW ...../...../.....

INTERVIEWER

NAME.....

INTERVIEWER CODE NUMBER.....

**PART 1: SOCIO-DEMOGRAPHIC DATA:**

1.1 Age of respondent

----- years

1.2 Which ethnic group do you belong to?

- Akan .....1 ☐
- Ewe.....2
- Ga.....3
- Hausa.....4
- Dagomba.....5 ☐
- Other..... 6

1.3 What is your religious denomination?

- Christianity.....1
- Islam .....2
- Traditionalism.....3
- No religion.....4

- Other..... 5

1.4 What is your highest level of education?

- No education.....1
- Primary.....2
- Secondary.....3
- Tertiary.....4

1.5 What is your employment status?

- Unemployed .....1
- Self- employed.....2 ☐ Employed (public sector).....3 ☐ Employed (private sector).....4

1.6 What is your marital status?

- Single.....1
- Married .....2 ☐ Cohabiting .....3 ☐
- Separated.....4
- Divorced.....5

1.7 How old is you last child? ----- Months

**PART 2: INFORMATION ON POSTPARTUM FAMILY PLANNING**

2.1 Have you heard about family planning?

- Yes.....1 ☐
- No.....2

2.2 Where/ from whom did you hear about family planning?

- Nurse/ midwife.....1
- Doctor .....2
- Friend/Relative.....3
- Media: Books/Radio/Television.....4
- Other.....5

2.3 In your own words, what do you understand by family planning?

-----

-----

2.4 What family planning/ contraceptive methods do you know?

Condoms: male/female.....1

☐

□

- Injectables: depo provera/norigynon.....2
- Implants: jadelle/implanon/sino implant.....3
- Pills.....4
- Intra-uterine contraceptive device.....5
- Sterilization .....6
- Lactational Amenorrhoea method.....7
- Withdrawal.....8
- Other .....9

2.5 Can a woman who has recently given birth use a family planning method?

- Yes.....1
- No.....2

2.6 If yes, how soon after birth can she start using the family planning method?

.....months

2.7 What method(s) can such a woman use?

- Condoms: male/female.....1
- Injectables: depo provera/norigynon.....2
- Implants: jadelle/implanon/sino implant.....3
- Pills.....4
- Intra-uterine contraceptive device.....5
- Sterilization.....6
- Lactational Amenorrhoea method.....7
- Withdrawal.....8
- Other .....9

2.8 In your opinion how soon after delivery can a woman get pregnant?

.....months

2.9 Can a woman get pregnant, soon after delivery, before she resumes her menses/period?

- Yes.....1
- No.....2
- I don't know.....3

2.10a Do you use any form of family planning?

□



☐

- Yes.....1  
No.....2

2.10b If yes, which method do you use?

- Condoms: male/female.....1
- Injectables: depo provera/norigynon.....2
- Implants: jadelle/implanon/sino implant.....3
- Pills.....4
- Intra-uterine contraceptive device.....5
- Sterilization.....6
- Lactational Amenorrhoea method.....7
- Withdrawal .....8
- Other .....9

2.11 How soon after your last child did you start using the family planning method?

.....months

### **PART 3: ACCESSIBILITY TO FAMILY PLANNING SERVICES**

3.1 Where is the family planning service located?

- Within the hospital premises.....1
- Close to the hospital premises.....2
- Far from the hospital premises.....3

3.1b By what means do you get to the family planning centre?

- By foot.....1
- By public transport.....2
- By private transport.....3
- Other.....4

3.1c If you use public transport, how easy is it to get a vehicle to the centre?

- Very easy.....1
- Easy.....2
- Difficult.....3
- Very difficult.....4

☐

Very

3.2 How long does it take you to get there?

.....minutes

3.3 How much is the transport fare from your house to the facility?

☐



□

Cheap.....1

KNUST



□

□

Affordable.....2

• Expensive.....3

• Very expensive.....4

3.4 Is your place of residence far from the family planning service/clinic?

• Yes.....1

• No.....2

3.4b If yes, does the distance affect your use of the family planning service?

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3.5 Do you have to pay any fees/ money for using the family planning services?

• Yes.....1

• No.....2

3.6 If yes, how much do you have to pay?

.....Ghana cedis

3.6b Which of these best describes the amount you have to pay?

• Cheap.....1

• Affordable.....2

• Expensive.....3

• Very expensive.....4

3.7 At the family planning centre, what language is used for the counselling sessions?

• English.....1

• Twi.....2

• Fante.....3

• Ewe.....4

• Hausa.....5

• Dagomba.....6

• Other.....7

3.8 Do you fully understand what the health staff are saying in the language used for the counselling sessions?

• Yes.....1

• No.....2

3.9 Is there a specific family planning method that you prefer and is this method available to you at the family planning centre?

- Yes.....1
- No.....2

#### **PART 4: QUALITY OF POSTPARTUM FAMILY PLANNING SERVICE**

4.1 How would you describe the environment in which the family planning service is provided? Is it private and are you satisfied with the reception?

- Yes.....1 ☐
- No.....2

4.2 Do you have to wait for long before being attended to?

- Yes.....1 ☐
- No.....2

4.3 If yes, is there a waiting area available to you?

- Yes.....1
- No..... 2

4.4 Would you describe the service provided by the staff at the family planning clinic as satisfactory?

- Yes.....1 ☐
- No.....2

4.5 Which of these best describes your service provider?

- Friendly and up-to-date on family planning issues.....1
- Indifferent.....2
- Unfriendly and not up- to- date on family planning issues.....3

4.6 Does your provider tell you about possible side- effects you might have with the family planning(contraceptive) method you use?

- Yes.....1
- No.....2

4.7 Has your provider told you what to do when you experience any problems or side-effects with any of the methods?

- Yes.....1
- No.....2

4.8 Would you return to this family planning service provider?

- Yes.....1
- No.....2

□

4.9 Would you refer a relative or friend to this provider/ facility?

- Yes.....1
- No.....2

## **PART 5: PARTNER SUPPORT IN POSTPARTUM FAMILY PLANNING**

5.1 Have you discussed the use of contraceptives with your partner/ spouse?

- Yes.....1
- No.....2

5.1b If yes, which does your partner prefer?

- Male contraception.....1
- Female contraception.....2

5.2 How does your partner feel about the use of contraceptives soon after delivery?

- Strongly agrees.....1
- Agrees.....2
- Indifferent.....3
- Disagrees.....4
- Strongly disagrees.....5

5.3 Is your husband willing to assist you financially to obtain contraceptives or to have a procedure performed?

- Yes.....1
- No.....2

5.4 Do you think how your partner feels influences your willingness to use family planning soon after birth?

- Yes.....1
- No.....2

5.5 Who makes the final decision about using family planning?

- You.....1
- Your partner .....2
- Other.....3
- Both.....4

□

THANK YOU